The Mental Health and Addiction Program at St. Joseph's Healthcare Hamilton specializes in the assessment and treatment of mental illness and addiction. We offer evidence-based services in anxiety disorders, mood disorders, schizophrenia and psychotic disorders, neurocognitive disorders, eating disorders, borderline personality disorder and emotion regulation difficulties, substance use disorders, mood difficulties related to the reproductive cycle, and dual diagnosis (combined mental health concerns and intellectual disabilities). The services are primarily offered for transition aged youth (17-25), adults and seniors.

Questions about the referral process? Please call: 905-522-1155, x. 36499, or Email: connectmhap@stjoes.ca

In order to help us provide the best care, please include the following (if possible):

- Relevant lab and test results
- Previous psychiatric consultations or discharge summaries
- List of medications (past and present medications, please attach pharmacy medication list)
- Physical findings
- Psychological/psychiatric reports

Please note for the following services:

- For the Assertive Community Treatment Team (ACTT), please fax completed form to
  - Hamilton ACTT (ACTT1 and ACTT2) - Fax 905-528-8442
  - Brant ACTT - Fax 519-758-1971
  - Haldimand Norfolk ACTT - Fax 519-426-0971

- For Centralized Rehabilitation Resource Clinic (CRRC) please also complete and submit the supplemental form found on www.stjoes.ca/crrc and fax to 905-381-5612.

- For Dual Diagnosis referrals, patient must have a Global IQ of 70 or less prior to their 18th birthday.
  (Please also attach the neuropsychological testing report if available).

- For Eating Disorder referrals, please also complete the Eating Disorders Referrals Section of this form.

Other Information:

Patient and Family Collaborative Support Services: Offers peer support for individuals and family members of individuals with lived experience of a mental health or addiction issue. Please contact 905-522-1155 ext. 39559. Self-referrals are welcome.

Research Participation: Eligible patients may be contacted by St. Joe's researchers to gauge their interest in research participation. The choice to participate in research or not will have no effect on patient care. Patients may withdraw from research contact at any time by informing their care team at St. Joe's.

There may be a wait for service.

If your patient is in crisis and is requiring immediate help, please contact your local crisis service or direct them to your nearest emergency department.

<table>
<thead>
<tr>
<th>Hamilton COAST</th>
<th>Haldimand Norfolk CAST</th>
<th>Niagara COAST</th>
<th>Brant St. Leonard's</th>
<th>Halton COAST</th>
</tr>
</thead>
<tbody>
<tr>
<td>(905-972-8338)</td>
<td>1-866-487-2278</td>
<td>1-866-550-5205, x. 1</td>
<td>519-759-7188 or 1-866-811-7188</td>
<td>1-877-825-9011</td>
</tr>
<tr>
<td>Barrett Centre</td>
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<td></td>
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</tr>
<tr>
<td>(1-844-777-3571)</td>
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</tr>
</tbody>
</table>

Please DO NOT FAX COVER PAGE
# Outpatient Referral Form for Providers

Phone: (905) 522-1155 Ext. 36499   Fax: (905) 389-3815   Email: connectmhap@stjoes.ca

## Client/Patient Information

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Legal Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Name:</td>
<td>Date of Birth: (yyyy/mm/dd)</td>
</tr>
<tr>
<td>Health Card Number:</td>
<td>VC:</td>
</tr>
<tr>
<td>Address:</td>
<td>Unit:</td>
</tr>
<tr>
<td>City:</td>
<td>Postal Code:</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

*Primary Contact Phone: ________________________

Mobile | Landline | Mobile | Landline |

Can a message be left at this number? Yes | No

Can we use text for communication? Yes | No

If yes, number to text: ________________________

Can we use email for communication? Yes | No

If yes, email address: ________________________

Alternate Contact Information:

Consent to contact? Yes | No

Community Treatment Order? Yes | No

Capable to make treatment decisions? Yes | No

Substitute Decision Maker (SDM): Yes | No

SDM Name: ________________________

Relationship: ________________________ Phone: ________________________

Emergency Contact Name: ________________________

Relationship: ________________________ Phone: ________________________

## Referral Source Information

* Provider Referring: ________________________

Facility: ________________________

Specialty: ________________________ Billing #: ________________________

Contact Person: ________________________

Fax: ________________________

Does client have a family physician? No | Yes

Name of family physician: ________________________

Is family physician part of FHT? No | Yes

If yes, have internal services been accessed? Yes | No

* Phone: ________________________

Backline: ________________________

Fax: ________________________

Consent

* Patient is aware of this referral and has consented to their health information being collected from various sources to make decisions regarding care.

Yes | No

Special Needs

Preferred Language: English | Other ________________________

Is an interpreter required? Yes | No

- Cognitive Impairment
- Hearing Impairment
- Sight Impairment
- Mobility/Fall Risk
- Sensory (smell/light)
- Unable to attend clinic
- Other: ________________________

## Presenting Concerns/Referral Goal

(i.e. diagnostic clarification, medication review, 2nd opinion, treatment)

* Reason for Referral: New Request | Re-referral

* Indicate Urgency: Urgent (< 2 weeks) | Non-urgent

* Please describe presenting problems, current symptoms, and reason for urgency:

How long has this been a concern? Less than one month | 1-6 months | More than 6 months

Currently receiving treatment for this concern? No | Yes

If yes, Provider name, discipline and type of treatment: ________________________

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**Version 2.0 - 2019/11/14**

CONNECT - Mental Health & Addiction Outpatient Program
Outpatient Referral Form for Providers

Client/Patient Name: __________________________

Past/Present Psychiatric Diagnoses

<table>
<thead>
<tr>
<th>Past</th>
<th>Present</th>
<th>Past</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder</td>
<td>☐</td>
<td>☐</td>
<td>Anxiety Disorder</td>
</tr>
<tr>
<td>Schizophrenia/Schizoaffective</td>
<td>☐</td>
<td>☐</td>
<td>Depression</td>
</tr>
<tr>
<td>Eating Disorder</td>
<td>☐</td>
<td>☐</td>
<td>Psychosis (Hallucinations/Delusions)</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>☐</td>
<td>☐</td>
<td>Neurocognitive Disorder</td>
</tr>
<tr>
<td>Post Traumatic Disorder</td>
<td>☐</td>
<td>☐</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Treatment History - (Please attach assessments, discharge summaries, progress notes from other agencies, hospitals or therapies)

Hospital admission(s) for: mental health concerns: ☐ No ☐ Yes addiction concerns: ☐ No ☐ Yes
ER visit(s) for: mental health concerns: ☐ No ☐ Yes addiction concerns: ☐ No ☐ Yes
Involvement with other agencies and/or therapy? ☐ No ☐ Yes

Please provide details of when, where and outcome of treatment history. Information is necessary to complete intake process.

Medical History (Please attach relevant CURRENT and PAST medical information, i.e. respiratory, cardiac, metabolic)

Please Describe: __________________________

Indicate all that apply:
☐ Acquired Brain Injury ☐ Developmental Disability ☐ Neurological Disorder ☐ Pregnant/Post-partum Due Date: ____________

Substance Use

Use alcohol or drugs weekly or more often? ☐ No ☐ Yes
Spend a lot of time either getting, using or recovering from the effects of alcohol/drugs? ☐ No ☐ Yes
Continue to use alcohol or drugs even though it’s causing problems? ☐ No ☐ Yes
Experience withdrawal problems or use substances to stop being sick? ☐ No ☐ Yes

<table>
<thead>
<tr>
<th>Substance</th>
<th>Amount Used</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance</td>
<td>Amount Used</td>
<td>Frequency</td>
</tr>
<tr>
<td>Substance</td>
<td>Amount Used</td>
<td>Frequency</td>
</tr>
</tbody>
</table>

Risk Issues (Please check all that apply)

<table>
<thead>
<tr>
<th>Risk Issue</th>
<th>Yes</th>
<th>No</th>
<th>If Yes, when?</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Attempt</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Suicide Ideation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Deliberate Self-harm</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Homicidal Threats/ideation</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Violent/Aggressive Behaviour</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Legal Involvement</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Homelessness/Risk of</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Lives Alone</td>
<td>☐</td>
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<tr>
<td>Other:</td>
<td>☐</td>
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</tbody>
</table>
Medication/Supplements: (PSYCHIATRIC and NON-PSYCHIATRIC medications including opiate replacement therapies. Please attach additional information if required.)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose/Frequency</th>
<th>Current</th>
<th>Past</th>
<th>Start Date</th>
<th>Response/Adverse Effects</th>
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</table>

Eating Disorders Clinic Referrals: Please complete the following sections and submit with the required investigations.

Please note the SJHH Eating Disorders Clinic is an outpatient clinic and does not have day hospital or inpatient treatment and does not offer meal supervision. Referral is for consultation/recommendations. Treatment will be offered if appropriate. Considerations include medical stability, symptom severity, psychiatric comorbidity. Clients must have a BMI over 16.

Current Physical Status: Please complete in full as this information is necessary to determine appropriate treatment.

Height (cm): ________________  Weight (kg): ________________  BMI: ________________

Weight Loss: ☐ No  ☐ Yes  Weight Gain: ☐ No  ☐ Yes  Please indicate change: ______ kg over ________ (time period)

Has this patient ever received treatment for his/her eating disorder? ☐ No  ☐ Yes

If yes, where and when: ____________________________

Current Symptoms: Please check all that apply and include frequency. Information is necessary to determine appropriate treatment.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Frequency</th>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restriction</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>Diet Pills</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Binge Eating</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>Insulin Restriction</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Vomiting</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>Diuretics</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>Laxatives</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>Extreme distress with weight and shape</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Extreme Exercise</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>Other:</td>
<td>☐</td>
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</tbody>
</table>

Current Investigations: Mandatory - Please attach results from within the last three months.

☐ ECG  ☐ Calcium  ☐ Glucose  ☐ AST  ☐ Alkaline Phosphatase
☐ CBC & Diff  ☐ Magnesium  ☐ Urea  ☐ ALT  ☐ Vitamin B12
☐ Electrolytes  ☐ Phosphate  ☐ Creatinine  ☐ GGT  ☐ GGT
☐ Ferritin  ☐ If Binge Eating is the only reported symptom, please also complete Fasting Lipids

If your patient is in crisis and requiring immediate help, please contact your local crisis service or direct them to your nearest emergency department. In Hamilton, contact COAST (905-972-8338) or Barrett Centre (Toll Free 1-844-777-3571), in Haldimand Norfolk contact CAST (1-866-487-2278), in Niagara contact COAST Niagara (1-866-550-5205, ext. 1), in Brant contact Integrated Crisis Services; St. Leonard’s (519-759-7188 or 1-866-811-7188), and in Halton contact COAST Halton (1-877-825-9011).

______________________________  ____________________________
Referral Source Signature  Date Signed (yyyy/mm/dd)